Claims Clues

A Publication of the AHCCCS Claims Department August, 2003

New Codes to Replace AHCCCS' Local Codes

Many state Medicaid programs, including AHCCCS, have adopted local codes to address specific programs.

Under the Health Insurance Portability and Accountability Act (HIPAA), all local codes must be replaced with the appropriate HCPCS and CPT-4 codes. In addition, a number of new codes have been added to HCPCS to accommodate items that did not have codes before.

Providers may bill with the new codes for dates of service on and after October 1, 2003. Providers may continue to use the current AHCCCS-specific local codes for dates of service prior to January 1, 2004. For dates of service on and after January 1, providers must not bill with the AHCCCS-specific codes and must use the new codes.

This change in coding requirements applies to providers who submit claims electronically and on paper.

AHCCCS local codes include the "W," "Y," and "Z" codes as well as the Indian Health Service-specific codes (00090 – 00099).

AHCCCS will soon publish a crosswalk showing the local codes that are being eliminated and the new codes which must be used. The crosswalk will be published on the AHCCCS Web site at www.ahcccs.state.az.us. ❒

AHCCCS Determines Essure Is Not Covered Service

The AHCCCS Administration medical staff has determined that Essure, a new contraceptive device, will not be covered at this time.

Following a review of Essure, the medical staff determined that other forms of contraception are currently considered community standard of care and are included as covered services for AHCCCS recipients eligible for family planning.

The Essure system received FDA approval in November of 2002. ❒

State Budget Eliminates Funds for SES Program

Funding for the State Emergency Services (SES) program, one of two AHCCCS programs limited to emergency services, was eliminated from the fiscal year 2004 state budget effective July 1, 2003.

The SES program was funded exclusively with state funds. It covered individuals who were either undocumented or non-qualified aliens who would not otherwise have qualified for the Federal Emergency Services (FES) program. Typically these were single adults.

The FES program was ***not*** affected by recent budget changes and will continue as it has in the past, covering the medical emergencies of undocumented individuals and non-qualified aliens. Typically this group includes children and pregnant women, as well as those who are aged, blind or disabled. The vast majority of emergency services only recipients qualify under the FES program.

Payment of claims for SES recipients for dates of service through June 30, 2003 is contingent upon continued availability of fiscal year 2003 state funds. (Hospital services for the SES population have not been eligible for reimbursement since March 2002 due to lack of funding.) Patients seen under the SES program on or after July 1, 2003 may be billed directly for any medical services provided, as they will no longer be covered by AHCCCS.

There may be community resources available for referral of these individuals for medical services. Federally Qualified Community Health Centers are one such resource. Certain other community clinics have sliding fee scale arrangements for persons of low income.

Providers who have questions should call the AHCCCS Division of Fee for Service Management at (602) 417-4241. ❒

Reorganization Creates New FFS Division

The AHCCCS Administration has undergone a major reorganization designed to improve the agency's fee-for-service management, enhance its managed care business focus, and increase efficiency.

The reorganization involves three major changes:

- Creation of a single division -- the Division of Fee-For-Service Management -- that includes the clinical, administrative, and claims functions for acute and long term care fee-for-service activities. This division was created from units of the Office of Medical Management (OMM) and the Division of Business & Finance. The reorganization does ***not*** change any Claims Section policies and procedures, and providers should continue to submit fee-for-service claims to the AHCCCS Administration as in the past.
- Creation of a single division – the Division of Health Care Management -- that encompasses the clinical, administrative, and financial, functions for acute and long term care activities. This division integrates the former Office of Managed Care with units from OMM.
- Creation of a single unit – the Office of Community Relations – responsible for community relations, provider development, and Native American relationships. ❒

PA Unit Changes Mail Drop Number

The AHCCCS Prior Authorization Unit has changed its Mail Drop number as part of the recent reorganization.

The PA Unit's new address is:

801 E. Jefferson Street
Mail Drop 8900
Phoenix, AZ 85034

The PA Unit's telephone and Fax numbers remain unchanged. ❒

AHCCCS Approves Codes, Rate for ASC Group 9

Effective July 1, 2003, AHCCCS has approved codes and the rate for Ambulatory Surgical Center (ASC) Group 9.

The rate for group 9 is $1,331. A complete list of ASC groups and the CPT codes that are included in each group can be downloaded from the CMS Web site at www.cms.hhs.gov.

Not all CPT codes that have been approved by CMS for inclusion in an ASC group are AHCCCS-covered services.

Providers should confirm that a service is covered by AHCCCS prior to billing. ❒

Hospitals May Bill Circumcision with V50.2; Charges Must Be Reported as Non-covered

Hospitals may bill newborn circumcisions with diagnosis code of V50.2 (Routine or ritual circumcision).

However, all related charges must be reported in the Non-covered Charges field (Field 48) of the UB-92 claim form. Claims without non-covered charges will be denied.

AHCCCS ended coverage of routine circumcision for newborn male infants on October 1, 2002. AHCCCS no longer covers CPT-4 codes 54150 (Circumcision, using clamp or other device; newborn) and 54160 (Circumcision, surgical excision other than clamp, device, or dorsal slit; newborn).

To report medically necessary circumcisions on the CMS 1500 claim form, the appropriate ICD-9 diagnosis code documenting medical necessity must be used. Physicians should bill either with CPT-4 code 54152 (Circumcision, using clamp or other device; other than newborn) or 54161 (Circumcision, surgical excision other than clamp, device, or dorsal slit; other than newborn).

Prior authorization must be obtained for fee-for-service recipients. ❒